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Partnership Perspectives



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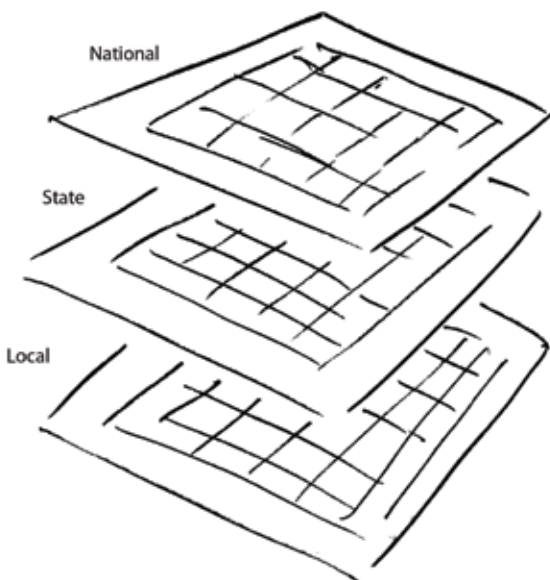
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Triple-Layer Chess: An Analogy for Multi-Dimensional Health Policy Partnerships

Karen J. Minyard, Tina Anderson-Smith, Marcia Brand, Charles F. Owens, and Frank X. Selgrath

Overview of the Concept

Evidence-based, strategic alignment of health policy agendas and investments across institutional boundaries and local, state, and national policy jurisdictions maximizes resources and strengthens outcomes related to state health policy. Based on this hypothesis, the Georgia Health Policy Center (GHPC) employs an approach to system change, research translation and policy application that is analogous to facilitating a game of three-dimensional chess.



Imagine any of a broad range of stakeholders simultaneously playing a complex game of chess on three boards - one above the other - representing each of three levels of activity within the health policy arena - local, state, and national. *Players*, in this instance, refer to individuals, organizations, or constituencies who influence health and health policy through their visions, agendas, investments, and actions. Table 2 provides examples of types of players and the relative moves they might make, or influence they might exert, in the Triple Layer Chess game of health policy and health improvement. To facilitate system change, GHPC translates findings from research in a way that assists players at each

level in understanding opportunities for winning the game by integrating their own strategic decisions with those of players on the other two levels. Checkmate outcomes occur when there is greater alignment among various parties both within and across the three levels, maximizing return on investments and magnifying the impact on health.

Alignment across Multiple Dimensions

The idea that greater coordination and collaboration among the multitude of players in the health arena is needed is nothing new:

An effective public health system that can assure the nation's health requires the collaborative efforts of a complex network of people and organizations in the public and private sectors, as well as an alignment of policy and practice of governmental public health agencies at the national, state, and local levels (Institute of Medicine, 2002).

Despite many efforts at greater collaboration across levels, more are needed (Tilson & Berkowitz, 2006). Multi-dimensional partnership models that reach across public-private or local-state-federal boundaries, such as “performance partnerships” used by the National Partnership for Reinventing Government (NPRG, 1999) and the collaborative models promoted by the national Turning Point program (Sabol B, 2002; Hahn, 2005) have succeeded in producing powerful changes to improve health.

Assertions Fundamental to the Triple-Layer Chess Analogy

It is a Frame of Mind, a Way of Thinking, a Set of Questions — In considering the relevance of the chess analogy, it may be tempting, particularly for actual chess players, to begin by asking practical questions such as - Who is the opponent? How do you determine what checkmate is? What are the rules for how different pieces are allowed to move? What does the board look like? Are there more than two colors? What if you cannot reach immediate alignment? (Fans of the board game may see Sandquist, 2001.) For the health system change purposes, however, we suggest using the metaphor as a way of thinking - an approach to problem solving that revolves around key strategic questions that are asked at all times with the three layer chess boards in mind. For instance, when engaged in a line of policy inquiry, GHPC researchers ask: What are the implications for local policy-makers and community leaders? How might state government or foundations create a more conducive environment for addressing the problem? What is the role of the federal government and national foundations or businesses in facilitating positive policy change? How do each of these levels of intervention and activity relate to one another? Evidence-based answers to these questions are translated for key public and private decision makers at local, state, and national levels with the intent to achieve greater alignment across the three dimensions and create opportunities for triple-layer chess. In cases where alignment does not exist and/or seems impossible to attain, players can work to strengthen the plays on one level. In the early stages, the intent and the strategic approach are important. The outcomes are often delayed, but are more likely to occur when people are considering a broader range of options. For example, when a policy at the federal level is not responsive to the local reality, local players can broaden their set of partners, strengthen local evaluation efforts, or more clearly articulate the local situation. Local players might also engage state leaders in understanding the local reality. Over time a stronger local and local-state alignment may create opportunities for creating more federal alignment.

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The complex interplay of actions on multiple levels in the health system is akin to systems thinking – “a paradigm or perspective that considers connections among different components, plans for the implications of their interaction, and requires transdisciplinary thinking as well as active engagement of those who have a stake in the outcome to govern the course of change” (Leischow and Milstein, 2006).

Playing the “game” requires strategy and creativity — The chess metaphor has evolved for the GHPC as a means to help frame and ultimately align critical decisions being made on

a continuous basis by a variety of stakeholders on multiple levels. The game of chess seems particularly applicable as it requires disciplined thinking, looking at the whole board (or system in the context of health), and thinking in advance about the intended, unintended, and delayed consequences of a particular move. In addition, chess players often make a move in present time thinking about the situations that move might create several plays into the future, all the while taking into account the possible responses and strategies of other players. Similarly, framing a health issue or policy decision using the metaphor may facilitate alignment among stakeholders by encouraging broad, strategic thinking that is less time-bound and restricted, and by influencing the information used, how the information is processed, and the range of possibilities considered.

Success requires seeing the “whole board” — In an article describing how he believes life imitates chess, Garry Kasparov, recently retired Chess Master, stated “There is something to be said about a chess players’ ability to see the whole board. Many [decision makers] are so focused on one problem, or a single aspect of a problem, that they remain unaware that solving it may require action on something that appears unrelated. It is natural for a chess player, by contrast, to look at the big picture” (Kasparov, 2005). Currently, in the health arena at local, state, and national levels, problem-solving activity appears to be taking place in a relatively isolated, crisis-dominated environment. Though this circumstance may be understandable due to the dynamic and complex nature of the factors influencing health and health policy, such deliberations often result in narrowly-defined, un-ambitious solutions considered by their designers to be absolute and complete. Here, again, the chess metaphor has value as a tool for framing issues. According to Kasparov, “There is no single solution to a chess game; you must consider every factor to produce a complete strategic solution.” Seeing the whole board in the instance of health is analogous to seeking to understand and consider the context of health – related systems, how they work, the relationships between various factors, the strategies and motivations of other players, and the influences affecting a particular problem or likely to leverage positive change – in order to devise meaningful strategies that increasingly align interventions and work toward checkmate.

The game of chess seems particularly applicable as it requires disciplined thinking, looking at the whole board (or system in the context of health), and thinking in advance about the intended, unintended, and delayed consequences of a particular move.

Application: Playing the Game

Play can be initiated at any level, by any player, at any time. Case examples demonstrate the game being initiated at the national, state, and local levels and moving on the same, the other, and all three levels.

The National Game: Aligning Federal Programs Internally Based on Powerful Evidence of State and Local Needs

Marcia Brand is associate administrator for rural health policy in the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). The agency uses its \$6.6 billion annual budget (FY 2006) to expand access to quality health care for

all Americans through an array of grants to state and local governments, health care providers and health professions training programs. Marcia is a master Triple Layer Chess player. Her national game includes leading a Health and Human Services (HHS) Rural Task Force that spanned across all 12 HHS divisions to assess how to better expand and improve the provision of health care and social services in rural America. She also works with the National Advisory Committee on rural Health and Human Services, coordinates with other governmental agencies such as those focused on research and mental health, and informs the regulatory process as it relates to rural health. The Office of Rural Health Policy has natural national-state and national-local strategies. Through these strategies Marcia collaborates with State Offices of Rural Health and State Rural Health Associations nationwide. The Office's grant programs for outreach, network development, planning, emergency medical services, and the Mississippi Delta create national-local links.

In a recent expansion of a pharmaceutical program, Marcia was able to play on all levels simultaneously. She coordinated knowledge of national regulation across federal divisions, mobilized regional and state organizations (State Offices of Rural Health, State Hospital Associations, the Delta Regional Commission and the Appalachian Regional Commission), and provided technical assistance to local hospitals. This example of triple layer checkmate worked to fill in the healthcare gaps for people who live outside the economic and medical mainstream and resulted in more affordable access to medications for rural people.

Marcia has learned that playing triple layer chess does not come without challenges. There is always the need to balance rural needs with limited resources. There is also a balance between those who might abdicate rural responsibility and those who have a rural bias that everything rural is good. Marcia has found that partnerships are often easier when a financial or grantee relationship exists. Other relationships may take more time investment.

The triple layer environment is very complex and constantly changing. Interest in rural issues varies within and between local, state, and federal governments and this influences legislation, budget, and priorities. As interest group priorities change rural efforts are influenced. Leadership is key. In other words, it helps to have people at all levels who know how to play the game.

The State Game: Aligning Public and Private Investments Based on Community Learnings

Charles Owens is the Executive Director of the Georgia State Office of Rural Health. Georgia's State Office of Rural Health (SORH) works to improve access to healthcare in rural and underserved areas and to reduce health status disparities. The Office oversees programs related to primary care, hospitals, migrant health, homelessness, professional shortages, and rural networks.

Charles has created state-state partnerships with a variety of state focused groups such as the Georgia Hospital Association, HomeTown Health (a rural hospital association), public health, Area Health Education Centers, the Medical College of Georgia and many others that have resulted in investments in rural health.

The Office made a state/national move when a partnership was built with the Robert Wood Johnson Foundation's Southern Rural Access Program for rural investments. Another state-national collaboration exists with the federal Office of Rural Health Policy, which results in federal government investments in Georgia's rural programs. The Office also has many state/local partnerships through investment of state resources, the Medicare Rural Hospital Flexibility Grant Program, Migrant Health and others. The focus of these efforts is to provide healthcare to meet individual community needs. Healthcare is provided in a manner that is receptive and through a vehicle that the community can and will support. The focus is a healthcare system that networks the various delivery models and improves the lives of the citizens of the area. This model promotes the development of the local game through incentives for local partnerships to solve rural health challenges.

Healthcare is provided in a manner that is receptive and through a vehicle that the community can and will support.

Spring Creek Health Cooperative (SCHC) is an example of triple layer checkmate. The SCHC is a partnership across four southwest Georgia counties in which providers, public health, and community leaders seek to improve health through disease management, pharmaceutical access, health screenings, and patient education. The SCHC began through the support and encouragement of the SORH and has become somewhat of a money magnet. Because the health needs in this geographic region are so great, many are interested in helping. They just needed a credible entity in which to invest. Spring Creek provided that investment entity. In this case, a simple state-local move resulted in a full scale Triple Layer Chess game with national, state, and local, public and private investments of more than one million dollars. Spring Creek is now able to generate income of \$345,000 per year for the services it offers, which contributes greatly to their sustainability.

The Local Game: Aligning Local Partners with a Common Purpose

Frank Selgrath was the founding director of the Coastal Medical Access Program (CMAP) in Brunswick, GA, which began in 2002. CMAP's mission is to provide pharmaceutical assistance, chronic disease case management and free access to primary health care for medically needy residents of Camden, Glynn and McIntosh Counties in Southeast Georgia. This is accomplished through collaboration among the medical community, faith-based organizations, local businesses and volunteers.

Frank's Triple Layer Chess playing abilities were apparent early. The local game is apparent in the mission, "collaboration among the medical community, faith-based organizations, local business, and volunteers." These local collaborations have resulted in: two free clinics providing 3,504 visits for 1008 patients (75% of which are ER diversions); five MedBank locations providing \$6.6 million in pharmaceuticals for 2,312 patients; and case management for 408 chronically ill patients. Local volunteers clocked 23,000 hours over three years valued at nearly one million dollars. Other in-kind contributions of space, equipment, and supplies are valued at more than one-half million dollars. This is clear indication that there is mastery of the local game.

Leveraging Resources

Original-Seed Money

Philanthropic Collaborative of Rural Georgia \$185,000 in 2002.

Since Then	
Public funding	\$1,053,230
Private Funding	\$1,325,700
Total Cash	\$2,378,930
Volunteer Hours	
2002	2,040
2003	10,600
2004	9,750
Total	22,750 Hours
Value	\$980,000
In-Kind Contributions	
1. Free Space	\$200,000
2. Equipment/Supplies	\$376,000
Total In-Kind	\$1,866,000 In-Kind
Total Resources Raised	
	\$3,934,930

Table 1



network applied for and was granted one of the federal Office of Rural Health Policy's Network Development grants.

Frank also played the local-state game. CMAP was founded with a state access grant and the collaborative took advantage of the technical assistance provided by the GHPC to build sound organizational and programmatic foundations. CMAP leaders also built local-state relationships with the Georgia's Office of Rural Health Services and the Georgia Rural Health Association. The organization was recognized as the state's Outstanding Rural Health Agency for 2003. Frank made a local-national move when the

All of Frank's local, local-state, and local-national strategies paid off with an opportunity to play on all three levels. The Georgia Governor's Office received a state planning grant from HRSA and chose four communities to serve as pilots in developing access for uninsured employees in small business. CMAP was chosen as a pilot site because of their previous organizational and programmatic success. This is an example of a national, state and local collaboration that puts CMAP in the national limelight and creates more opportunities to leverage resources. Frank's Triple Layer Chess moves are a story of leveraging resources as can be seen by Table 1.

Implications for Community-Campus Partnerships for Health

For communities, some partnerships may already be masters of the local-local game – having brought local partners together to address community needs. An important lesson from this work is don't be afraid to look up – bring state-level partners into your local game and leverage them into relationships with federal-level players. The nine *Principles of Good Community-Campus Partnerships* (CCPH, 1998) still apply and are appropriate even for partnerships that bridge the state and federal levels.

The Health Policy Center experience provides insight for the campus applications. In 1996, Georgia rural health systems faced a bleak future. A study for the state Medicaid program revealed that in rural markets, hospitals, physicians, pharmacies, and nursing homes were at risk of closure. It appeared that the solution would involve the development of new local and regional partnerships among community leaders and healthcare providers to strengthen local health care systems.

In partnership with the SORH, GHPC designed, tested, and implemented a community intervention to facilitate the development of rural health networks across the state. What began in 1996 as an intensive approach to understand and facilitate network development processes in 30 rural health systems in Georgia has since become a dynamic, iterative process of research and reflection, translation, and implementation of policy and practice at the local, state, regional, and national levels – a virtual game of triple-layer chess (Minyard, et al., 2003).

- ♦ **THE LOCAL GAME** — Tools and methods derived from field research and practice between 1996 and 2001 included: the creation of a theory of change for health system transformation, “Keys to Success” for system development, a self-assessment tool for measuring a network’s progress toward transformation goals, and the design of a technical assistance approach tailored to networks’ needs.
- ♦ **THE STATE GAME** — In 2001, findings were translated for state policy makers and philanthropies through reports, issue briefs, and presentations, resulting in a partnership that leveraged more than \$2 million for grants and technical assistance. Iterative research enabled the refinement of the “Keys to Success” and the creation of Developmental Milestones against which networks could measure progress.
- ♦ **THE NATIONAL GAME** — In 2002, the GHPC was contracted by the Federal Office of Rural Health Policy to apply their evidence-based approach to technical assistance and network development to support 41 Federal Office of Rural Health Policy Network Development Grantees. In consort with this activity, the GHPC developed a framework for tailoring technical assistance approaches, a logic model for network development, and an inventory of leadership characteristics necessary for network development. These tools are shared with other states through Community Health Systems Development Institutes conducted by the GHPC.

Since 1996, findings from GHPC’s rural health system development practice and research have been integrated into local, state, and national policy and translated into useful tools and technical assistance methods now applied in almost every state. Perhaps even more relevant, though, is that the triple-layer chess metaphor inspired the translation strategies used by the Center and made extensive dissemination and incorporation possible. Further, findings from the technical evaluation and from providing technical assistance to federally-funded communities enable the Center to provide feedback to the Federal Office of Rural Health Policy regarding opportunities to strengthen grant programs and align internal programmatic resources to better support states and rural communities. University partners hold powerful starting positions for playing Triple Layer Chess and making the moves that result in triple layer checkmate.

Since 1996, findings from GHPC’s rural health system development practice and research have been integrated into local, state, and national policy and translated into useful tools and technical assistance methods now applied in almost every state.

Table 2

Examples of Potential Players Local, State and National	Types of “Moves” or Influence on the System
Community Representatives	Their needs and demands drive the system Firsthand experience enables diagnosis of system breakdowns Relationships and understanding uniquely prepare them to create community specific solutions needs Behaviors affect health status Communicate with state and national decision-makers
Health and Human Service Providers	Provision of individual and population-based services Volunteerism Application and advancement of clinical expertise Political engagement through associations
Insurers	Establish rates, scope of benefits Processes may affect or regulate access Partnering with Businesses
Government <ul style="list-style-type: none"> ◆ Elected and administrative ◆ Health, Economic Development, Transportation, Education, Labor, Public Safety, Justice, etc. 	Regulation Appropriation of funding Agenda-setting Partnering with private sector Grant making for local demonstrations Assuring budget accountability Working across agencies to align investments based on common visions
Businesses/Private Sector	Offer coverage Implement workplace wellness programs Exert market influence Invest in local programs which may impact their costs and employees’ health status Create employment that impacts individuals’ income (a determinant of health status)
Philanthropy	Invest in the resolution of health challenges Take risks and fund innovations Convene other stakeholders Leverage investments with other foundations interested in health improvement Make relatively autonomous investment decisions Fund evaluation and research to further innovation Provide operational and programmatic support for non-profit organizations working to improve health and community conditions
Faith-based Institutions	Provide a lens for understanding local perceptions, values, culture and need Source of wisdom in designing local initiatives and broader policies Serve as an educational and outreach resource Have established relationships and trust

Table 2 (continued)

Examples of Potential Players Local, State and National	Types of “Moves” or Influence on the System
Schools	Serve as conduit or enabler Educational success affects health status Influence opinion Programming to promote fitness in kids Policy decisions may impact health indicators such as obesity
Researchers	Partner with communities to support local decision-making, assessments, intervention design and evaluation Conduct research and translate findings to inform decisions Source of neutral, non-partisan data and analysis Provide facilitation and technical assistance Use unique vantage point to identify opportunities for system change and strategic alignment Contribute to health policy literature

References

- Community-Campus Partnerships for Health (1998). Principles of good community-campus partnerships. <http://depts.washington.edu/ccph/principles.html>
- Hann N. E. (2005). Transforming public health through community partnerships. *Prev Chronic Dis*. http://www.cdc.gov/pcd/issues/2005/nov/05_0072.htm.
- Institute of Medicine (2002). The Future of the Public’s Health in the 21st Century. *National Academies Press*, Washington, DC.
- Kasparov, G. (2005). The Great Game. *The Wall Street Journal Editorial Page*. A.16.
- Leischow, S.J., and Milstein, B. (2006). Systems thinking and modeling for public health practice. *American Journal of Public Health*, 96(3),403-405.
- National Partnership for Reinventing Government (1999). *Performance Partnerships Summary and Guiding Principles*. <http://govinfo.library.unt.edu/npr/library/fedstat/2572.html>.
- Minyard, K. J., Lineberry, C. I., Smith, T.A., Byrd-Roubides, T. (2003). Transforming the Delivery of Rural Health Care in Georgia: State Partnership Strategy for Developing Rural Health Networks. *The Journal of Rural Health*. 19 (Supplement): 361-371.
- Sabol B. (2002). Innovations in collaboration for the public’s health through the Turning Point Initiative: the W.K. Kellogg Foundation perspective. *J Public Health Manag Pract*. 8(1):6-12.
- Sandquist E.C. (2001). 3D Chess Federation. <http://www.3dchessfederation.com/index.htm>.
- Tilson H. and Berkowitz B. (2006). The public health enterprise: Examining our Twenty-First-Century policy challenges. *Health Affairs*, 25(4): 900-910.

About the Authors



As director of the Georgia Health Policy Center, Karen Minyard, PhD leads the policy, research, and technical assistance programs of the center. Before pursuing her PhD, Minyard worked in nursing and hospital administration for 15 years.

In 1996, Minyard was instrumental in the launch of “Networks for Rural Health”, an external facilitation and technical assistance program designed to help providers and community leaders in Georgia to build sustainable local systems focused on access and health status improvement. Through this work, 19 rural health network systems emerged and today, 15 continue to function as 501(c)(3) organizations. These networks have achieved direct fiscal and societal benefit for rural Georgians. Minyard serves as an officer on the founding board of the Community Health Leadership Network, a national partnership dedicated to helping communities achieve healthcare access, the board of the National Network of Public Health Institutes and has provided numerous consultations and presentations for groups and organizations that seek to build stronger health care systems.



Tina Smith, MPH, an advocate for community-driven strategies to improve health and health care, is a Senior Research Associate at the Georgia Health Policy Center. In this capacity, she examines the interactions between components of health systems including public and private perspectives at local, state and national levels and the implementation of strategies for building viable local health systems and regional partnerships. A rural Georgia native, Smith has been involved in efforts supporting access to care for rural citizens from a variety of perspectives over the past ten years. Her academic and professional experience includes hospital business development, public health program design, grassroots policy research, economic evaluation of existing programs, and community development. She has made numerous national presentations and provides technical assistance to leaders in other states who wish to support rural communities in improving the health of their residents.

Marcia Brand, PhD, is associate administrator for rural health policy in the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA). She has led HRSA’s Office of Rural Health Policy since January 4, 2001. As director of ORHP, Brand is responsible for health policy, research, and grant activities that promote better health care services in rural America. These programs include the Rural Outreach Grant Program, which requires partnering among grantees to improve health service delivery, and the Rural Network Development Program, designed to further collaboration among rural health care organizations. In 1997, Brand served as senior advisor to the Deputy Assistant Secretary for Health, during which time she worked on the Secretary’s Initiative on the Future on Academic Health Centers and prepared a report to the Secretary on the challenges facing academic health centers. From 1995 to 1997 she served as deputy director of the Office of Research and Planning for the Bureau of Health Professions.



Charles Owens was appointed in 2005 Executive Director of the Office of Rural Health Services by the Commissioner of the Georgia Department of Community Health. In this position, Owens oversees various programs including Hospital Services (rural hospital programs, SHIP, FLEX), the Georgia Farmworker Health Program (migrant health), and Primary Care (Primary Care Office, J-1

Visa Waiver, Health Professional Shortage Areas, and Scholarship and Loan Repayments). He also serves as an adjunct instructor for South Georgia Technical College located in Cordele, Georgia. Owens has worked in hospitals and healthcare for the past 14 years. Prior to his appointment, Mr. Owens served as the Chief Operations Officer of Dorminy Medical Center, a 75- bed rural general acute care hospital in Fitzgerald, Georgia.



Frank Selgrath is the late Executive Director of the Coastal Medical Access Project (CMAP), which was founded in 2002 as a nonprofit organization dedicated to helping uninsured people receive necessary medical assistance. CMAP provides free access to primary health care, MedBank pharmaceutical assistance and chronic disease case management for the medically needy. He used his determination and commitment to grow the organization into a landmark. In 2003, CMAP won the “Outstanding Rural Health Organization of the Year” award for the State of Georgia, presented by The Rural Health Association. A native of Pennsylvania, Selgrath served as a Board Member and Chairman of the Public Policy Committee of AMBHA (American Managed Behavioral Healthcare Association), Chairman of the Subcommittee on Mental Health Managed Care of the Pennsylvania Department of Public Welfare Medical Assistance Advisory Committee and Chairman of the Pennsylvania Department of Public Health Task Force on Substance Abuse.

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